Semi-Annual Report to the

Joint Legislative Oversight Committee

on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2010-11: Fall Report

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

December 1, 2010

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee every six months on progress made in seven statewide performance domains. This report is the fifth in a series of reports, with each report building upon previous reports. The following are highlights from each of the domains herein.

Highlights

Domain 1: Access to Services – (1) Overall, in recent years there has been an increase in the number of persons served by local management entities (LMEs) across the state which can be attributed to both improvements in LME data submission and an increase in admissions. The number of persons enrolled by LMEs increased in the past year in every disability group for adults but experienced decreases in every disability group for children/adolescents. (2) Almost all persons seeking emergent care are seen by a provider promptly after requesting services (98%); 84% of persons seeking urgent care are seen within 48 hours of requesting services; and slightly more than three-fourths of persons seeking routine care (non-urgent) are seen within fourteen calendar days. This represents an improvement in the timeliness of care for all three groups over the same period of the previous year.

Domain 2: Individualized Planning and Supports – (1) The majority (63%) of consumers with developmental disabilities report choosing the case manager at a much higher rate than reports of families in other states. In addition, an overwhelming number (88%) of consumers with developmental disabilities report their case manager is helpful in getting necessary services and supports. (2) The vast majority of consumers with mental health and substance abuse disorders report choosing the services they received as well as their treatment goals. However, fewer adolescents report being involved in choosing their services than other age groups and fewer adults report deciding their treatment goals compared to other age groups.

Domain 3: Promotion of Best Practices – (1) North Carolina Systemic, Therapeutic Assessments, Respite and Treatment (NC START) teams, Mobile crisis management teams and walk-in crisis and psychiatric aftercare programs are serving MH/DD/SA consumers in crisis in their communities, reducing the need for psychiatric hospitalization. The number of evidence-based mental health services has been increasing over the past two fiscal years. The number in evidence-based substance abuse services steadily climbed, but fell in the fourth quarter of SFY 2009-10, possibly due to the lag time needed for claims to be reported. (2) Admissions to the state alcohol and drug abuse treatment centers have increased in the last five years, while there has been a significant drop in admissions to state psychiatric hospitals since SFY 2006-07. This is likely due both to increases in community inpatient capacity and to policies to delay admissions when state hospitals are over capacity. (3) Readmissions to state psychiatric hospitals continue to remain higher for North Carolina than the nation.

Domain 4: Consumer-Friendly Outcomes – (1) While the majority of consumers with developmental disabilities report choosing where work and the staff who assist them at home and work, less than half of them report choosing where they live (which is the same pattern seen in all other states). (2) Mental health and substance abuse consumers continue to show meaningful improvements in various aspects of their lives after three months of service.

Domain 5: Quality Management Systems – (1) Provider performance reports are being piloted with Critical Access Behavioral Health Agencies (CABHAs) in the coming year. These public reports will give information to help individuals choose agencies that can meet their service needs (2) A new and improved reporting system for the Division's consumer outcomes system, Outcomes at a Glance 2.0, is

being implemented to replace the current online dashboard and will provide multiple options to query outcomes data including provider-level data.

Domain 6: System Efficiency and Effectiveness – (1) LMEs' timely and accurate submission of data to the Division has improved by 14 percentage points from first quarter of SFY 2008-09 to the fourth quarter of SFY 2009-10. (2) The Department of Health and Human Services has approved a definition and description of a new category of provider agency, Critical Access Behavioral Health Agency (CABHA), which is designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services. The CABHA will move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment. A rigorous monitoring protocol will assure that CABHAs continue to meet quality-of-care and patient-outcome standards.

Domain 7: Prevention and Early Intervention – (1) The North Carolina State Epidemiological Workgroup, comprised of staff from multiple state agencies, published an updated Substance Abuse Data Inventory, as a part of the North Carolina Strategic Prevention Framework-State Incentive Grant. This comprehensive report describes data repositories, data systems, and data sources that contain indicators of substance abuse consumption patterns and consequences in North Carolina for use by local and state program planners and evaluators.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2010-11: Fall Report

Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c) and builds on the measures reported in previous semi-annual reports (See Appendix A).

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. Timely access is essential for helping to engage people in treatment long enough to improve or restore personal control over their lives, and to prevent crises. Both the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures and Centers for CMS Quality Framework include measures of consumers' access to services.[1]

Measure 1.1: Persons Receiving Community Services

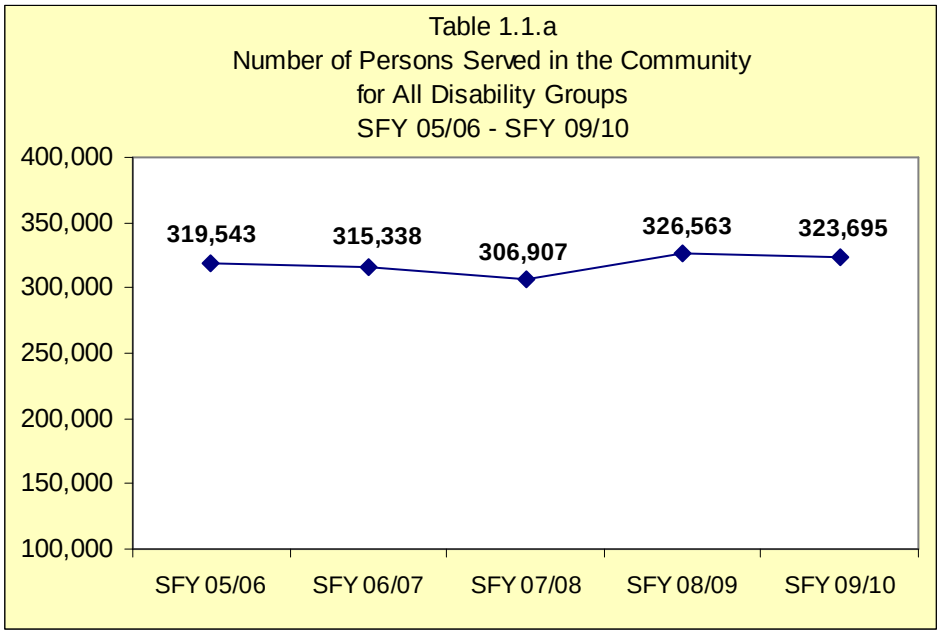
The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings whenever possible. Tracking the number of persons that the LMEs serve in communities provides a barometer of progress on this goal.

Measure 1.1 contains information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five state fiscal years, according to the LMEs' data on enrolled consumers. In the following three tables, the number of persons served is determined from data submitted to the Division's Client Data Warehouse (CDW) by the LMEs.[2]

Based on data the LMEs submit, Table 1.1.a. shows that the number of persons who have been served in the community over the past five state fiscal years experienced a steady decrease from SFY 2005-06 to SFY 2007-08 but has increased five percent since that time. The decrease during the earlier years reflects the closing of *inactive* records, as discussed in previous issues of this report . The increase in recent years reflects continued improvement in data quality, as LMEs have resolved issues around data submission and the Department has begun providing information to LMEs on consumers served by directly-enrolled Medicaid providers.

[1] See Appendix B for SAMHSA National Outcome Measures and Appendix C for CMS Quality Framework.

[2] The numbers for SFY 2008-2009 have been updated since the Fall 2009 Report.

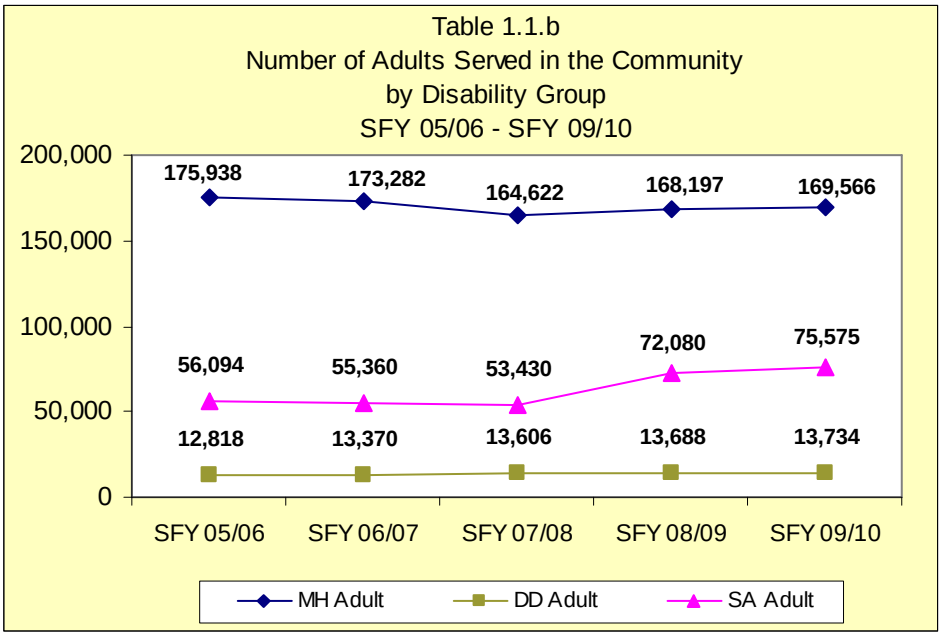


SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

Table 1.1.b. on the next page, shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years.

- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has decreased by approximately 4%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by 7%.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has decreased by 35%.

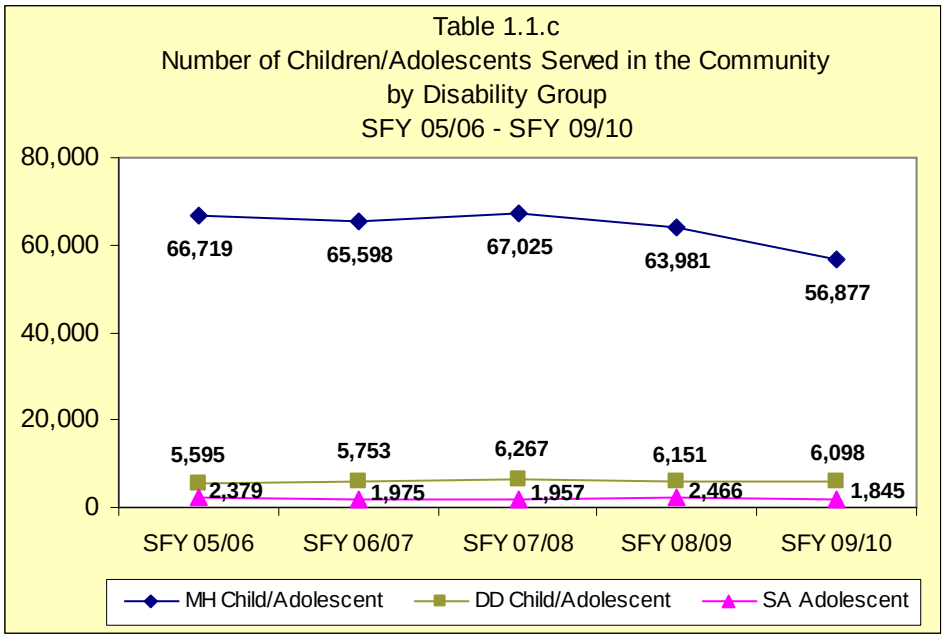
While there was a downward trend in treatment services to adults with substance abuse problems in SFY 2005-06 through SFY 2007-08, there was a 41% increase since that time. In the past state fiscal year, there has been a five percent increase in persons served. A very similar trend was occurring with adult mental health consumers, however there has only been a one percent increase in persons served in the past year. Services to adults with developmental disabilities have remained relatively stable over the past five fiscal years, with a seven percent increase since SFY 2005-06.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

Table 1.1.c, on the next page, shows the number of children and/or adolescents who received publicly-funded services in the community through the LMEs over the past five state fiscal years. Mental health and substance abuse were the two disabilities that experienced a decrease in the number of children and/or adolescents served in the community over that period. Children and/or adolescents with developmental disabilities saw a slight increase in numbers of persons served. However, all three disabilities experienced a decrease in the number of children and/or adolescents served in the community in the past year. This decrease in the past state fiscal year reflects Department of Health and Human Services (DHHS) efforts to improve management of community-based Medicaid services, as well as budget reductions in SFY 2009-10.

- **Children/Adolescents with a primary mental health diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 15%.
- **Children/Adolescents with a primary developmental disability diagnosis:** The number of children and adolescents served in the community over the past five years has increased by 9%.
- **Children/Adolescents with a primary substance abuse diagnosis:** The number of adolescents served in the community over the past five years has decreased by 22%.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2005 - June 30, 2010.

The Division expects the number of children and adolescents receiving mental health and/or substance abuse services to decrease, due to ongoing budget restrictions. The Division continues to work closely with LMEs and providers to develop and implement strategies to deliver services to children and adolescents efficiently, so that those in need of behavioral health care can receive it.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[3] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in greater trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Individuals who request care during crisis situations are usually seen very quickly. In the last quarter of SFY 2009-10:

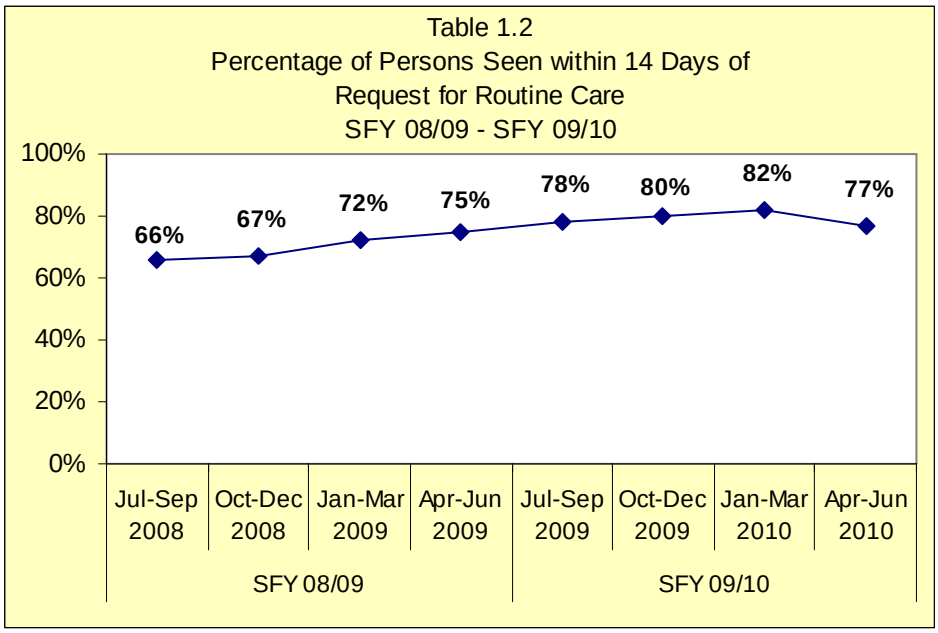
- 98% of those requesting care in emergency situations were seen within two hours.
- 84% of those requesting care in urgent situations were seen within 48 hours.

This represents a one percentage point improvement for each of these groups over the same period of the previous year.

In the last quarter of SFY 2009-10, just over three-fourths of persons requesting routine (non-urgent) services were seen, as shown in Table 1.2 on the next page. Looking over time, the percentage of all consumers seeking routine care over the past two state fiscal years who were *actually seen* by a provider

[3] Health Plan Employer Data and Information Set (HEDIS©) measures.

within the required timeframe of requesting services has steadily increased since the low of 66% reported in the first quarter of SFY 2008-09 to the high of 82% reported in the third quarter of SFY 2009-10.



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS, published in Quarterly Performance Contract reports.

While the Division and LMEs continue to emphasize the importance of timely access, the Division expects performance on this measure to level off due to the budget restrictions. The Division will continue monitoring the LMEs' progress in this matter as part of the *DHHS-LME Performance Contract*.

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to individuals (and to their families when appropriate) are more likely to engage them in service and encourage them to take charge of their lives. In addition, services that address what is important for them produce improved life outcomes more efficiently and effectively.

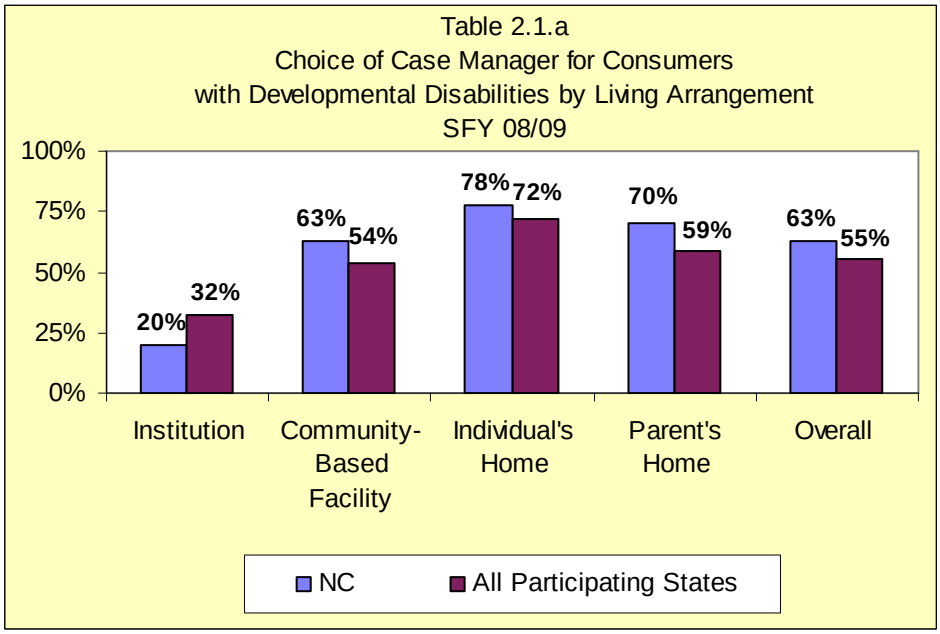
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers, and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice of Providers

Offering choice is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. In addition, having a voice in the service and staff person(s) that feel most supportive to an individual can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs

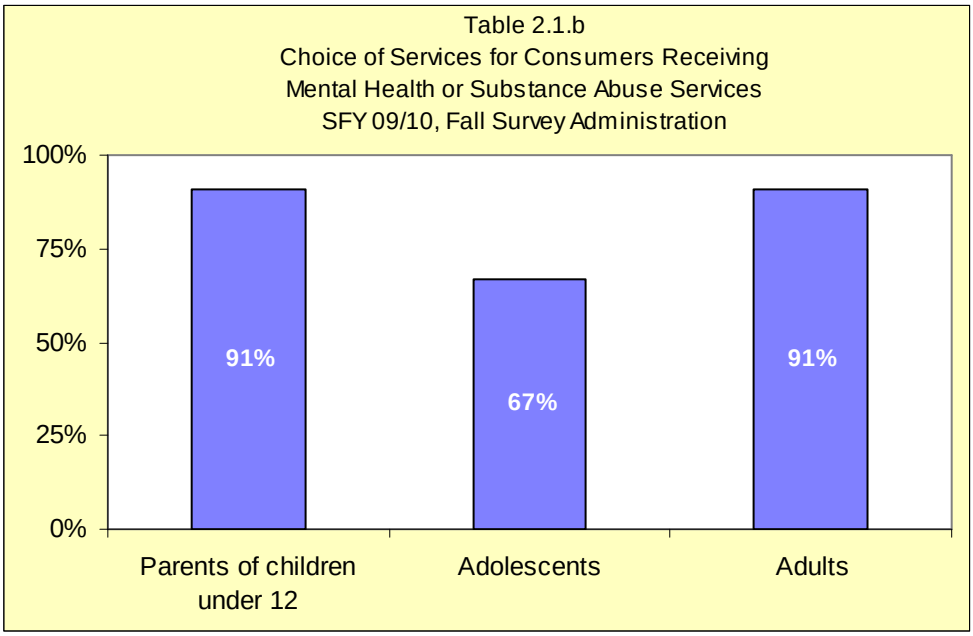
effectively and encourage them in a way that feels personally comfortable and supportive. The tables on the following pages address the extent to which individuals report having a choice in who serves them and/or the services they receive.

Consumers with Developmental Disabilities (Table 2.1.a): In annual interviews with DD consumers in SFY 2008-09, just under two-thirds of the consumers in North Carolina reported choosing their case manager compared to 55% reporting this for all participating states (see Table 2.1.a below). In SFY 2008-09, the Consumer Survey is able to provide responses based on where the consumer lives. As seen in the table below, consumers in North Carolina who reside in an institution were the least likely to report choosing their case manager (20%) while consumers living in their own home were more likely to report choosing their case manager (78%). (See Appendix D for details on the National Core Indicators Project's Consumer Survey.)



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): In the annual Division survey of persons with mental health or substance abuse disabilities, a large majority reported positive feedback regarding choosing the services they received. While parents of children under the age of 12 and adults were highly likely to agree that they had input into the services received, adolescents were less likely than these two groups to report helping to choose their services. (See Appendix D for more information on the Mental Health Statistical Improvement Project Consumer Survey.)



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

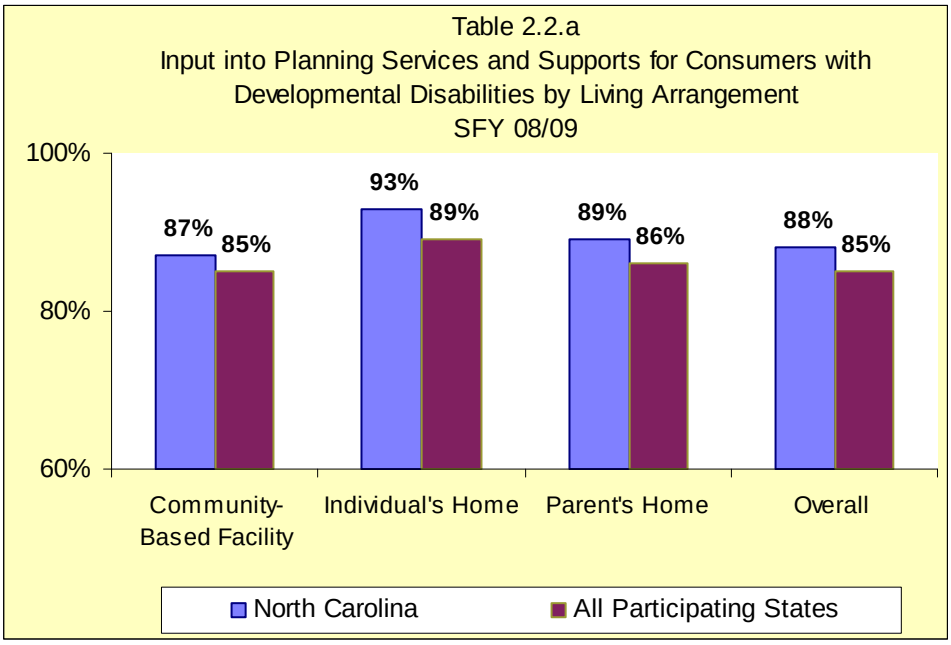
As the Legislature and Department revise service delivery mechanisms and respond to the current economic situation, some consumers will have to move to new provider agencies**. These changes are anticipated to result in a more cost effective system while still ensuring consumers their choice of service providers.**

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. Having a voice in choosing personally meaningful goals is a critical step toward recovery and self-determination. The Division requires a PCP for most persons who receive enhanced benefit services,[4] and has implemented a standardized format and training to ensure statewide adoption of this practice. As the following tables show, a large majority of consumers and their family members are involved in the service planning and delivery process.

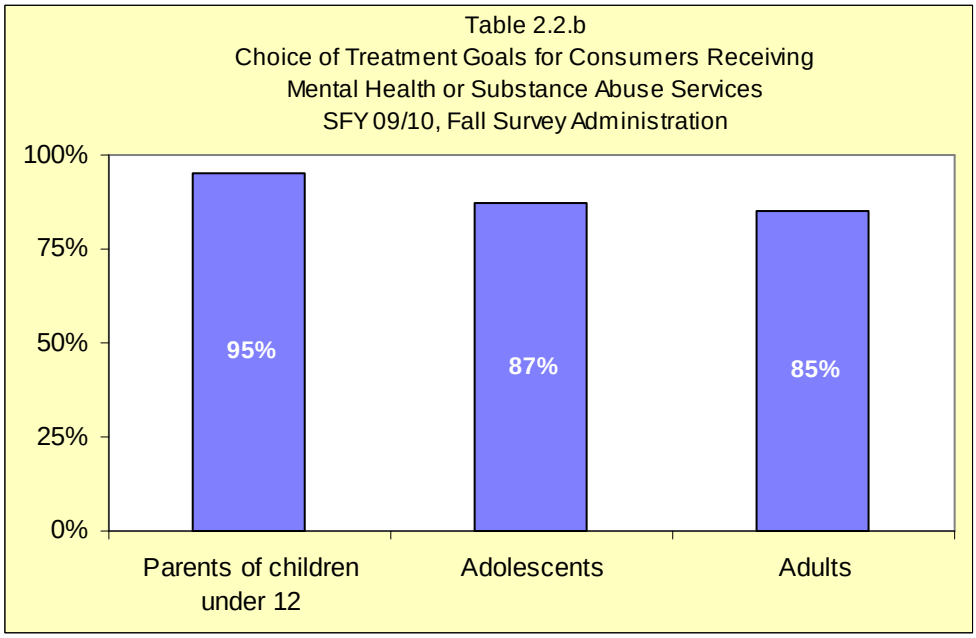
Consumers with Developmental Disabilities (Table 2.2.a): In SFY 2008-09, the large majority of North Carolina consumers with developmental disabilities (88%) reported that their case manager helps get them the services and supports they need (see Table 2.2.a on the next page). North Carolina consumers, regardless of where they live, were much more likely to report involvement in planning compared to consumers in all states using this survey. (See Appendix D for more information on this survey.)

[4] "The enhanced benefit service definition package is for persons with complicated service needs." *State MH/DD/SAS Plan 2005*, p. 58.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b): Every year in a consumer survey the Division asks mental health and substance abuse consumers about their having a choice of treatment goals. As Table 2.2.b shows, the vast majority of mental health and substance abuse consumers in the annual survey have consistently reported choosing or helping to choose their treatment goals across all groups reporting: parents of children under the age of 12, adolescents, and adults. More parents of children under the age of 12 reported having input into their treatment goals than adults and adolescents. (See Appendix D for more information on the Mental Health Statistical Improvement Project Consumer Survey.)



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

The state has made immense efforts to institute a recovery-oriented system of care that strongly encourages consumer and family participation in service planning and delivery, as evidenced by the positive results shown above. The continued growth and refinement of person-centered thinking will be critically important as LMEs transition consumers out of community support and residential services to more focused and appropriate care. **The impact of these transitions on the measures here will depend on how well LMEs and providers are able to indentify services that meet consumers' and parents' expectations and address critical service needs.**

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting proven models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown result in improved functioning of persons with disabilities, as well as promising practices that are recognized nationally. SAMHSA requires states to report on the availability of evidence-based practices as part of the National Outcome Measures in mental health and substance abuse prevention and treatment.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; offering incentives to providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services.

The North Carolina Practice Improvement Collaborative (NC PIC) provides guidance to the Division in determining the evidence-based practices that will be provided through our public system. With representatives of all three disabilities, the NC PIC meets quarterly to review and discuss practices that have been submitted for evaluation, examine issues that affect the readiness of the practice for adoption in our state, and to prioritize recommendations for the Division Director.

Measure 3.1: Persons Receiving Evidence-Based Practices

Community-based Crisis Services: An effective community-based service system starts with flexible, responsive crisis services that can come to the person in need and assist other responders on-site. This approach helps to prevent inappropriate, costly and unnecessary hospitalization or detention of persons undergoing a behavioral health crisis.

- NC START: As discussed in the Fall 2009 issue of this report, NC START (North Carolina Systemic, Therapeutic Assessment, Respite and Treatment) is a community-based crisis prevention and intervention program for people with Intellectual/Developmental Disabilities (I/DD) who experience crises due to complex behavioral health issues. The NC START program is comprised of six clinical teams, with two teams in each of the three regions in the state.

  Since implementation in January 2009, the demand for NC START services has increased dramatically. The following data comparison between the first complete reporting period of SFY09 (April-June) and SFY 2009-10 are reflective of the increase in demand:

NC START SERVICES	April – June 2009	July 2009 – June 2010
Cumulative caseload	158	394
Crisis intervention services (number of events)	160	667
Respite admissions	32	405
Planned services (hours provided)*	1392	6031
Training and education (hours provided)	334	2085

* Includes cross system crisis planning development, behavior support planning, developmental center transitions support, and intake and assessment.

Of the crisis intervention services provided in SFY 2009-10:

- 61% remained in their current setting
- 20% were admitted to crisis respite
- 7% were admitted to a community psychiatric hospital
- 6% were admitted to a state psychiatric hospital

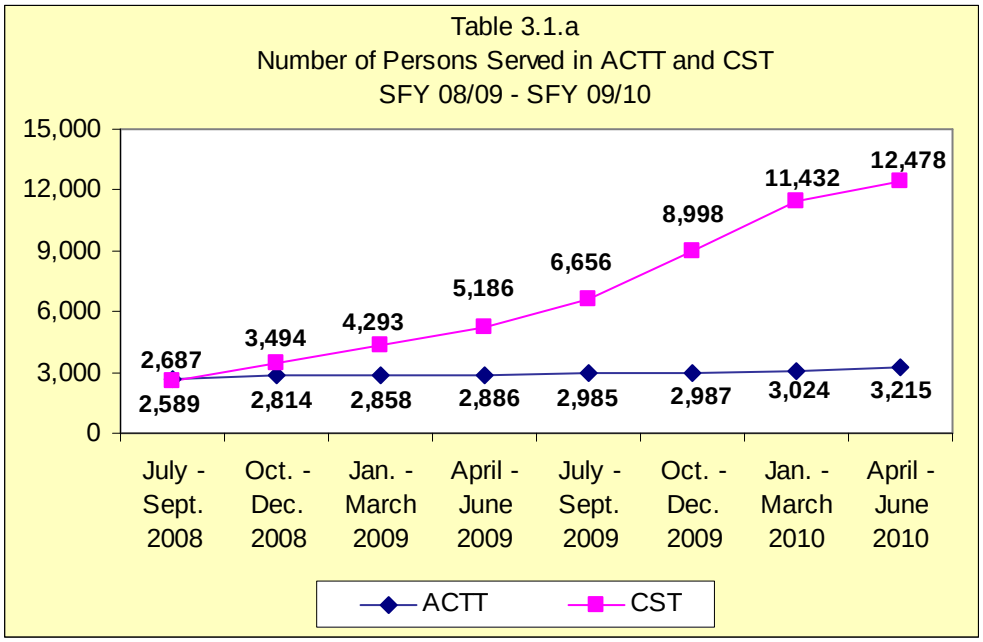
For additional information, the NC START annual report may be found at http://www.ncdhhs.gov/mhddsas/statspublications/reports/annual_report_nc_start_final.pdf

- Mobile Crisis Management: In 2008 the General Assembly appropriated funds for crisis services and General Session Law 2008-107 (HB2436) provided support for the development of 30 community Mobile Crisis Management Teams. From January through June 2010, Mobile Crisis Management Teams provided 12,806[5] crisis responses. Of those, 3,647 dispositions (28%) were for admissions to state hospitals, state alcohol and drug abuse treatment centers, or community hospitals, and only 93 (1%) involved jail or detention. All of the other cases (71%) involved dispositions to non-inpatient community settings.

- Walk-In Crisis and Psychiatric Aftercare: In SFY 2008-09, the Legislature provided funds to establish 30 walk-in crisis and psychiatric aftercare programs. These centers provide immediate care to adults, adolescents, or families in crisis directly or through telepsychiatry. From January 2010 through June 2010, these walk-in centers provided 139,065 services to consumers, 13% (17,954 services) of which were in response to crises. Among consumers who received services at walk-in centers, only 1% (1,434) required inpatient hospitalization, while in 94%of cases, individuals were connected to MH/DD/SAS providers in their communities.

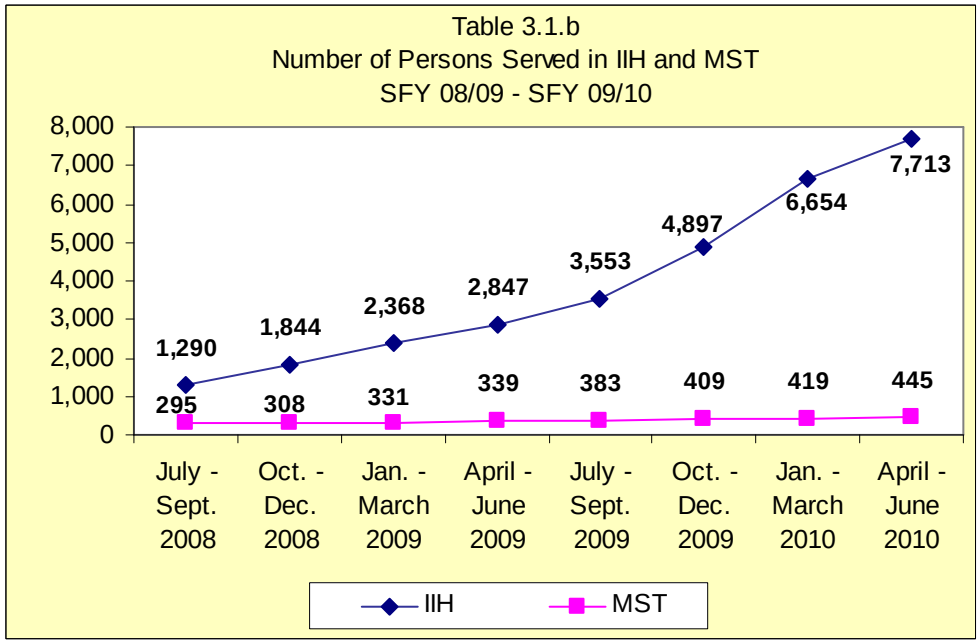
Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a on the next page, the number of adults served in ACTT has been increasing steadily over the past two years (an increase of 20% since the first quarter of SFY 2008-09), while the number of adults served in CST has increased almost 400% during the past two state fiscal years.

[5] These data reflect the services provided by Mobile Crisis Management Teams from all Local Management Entities except PBH.



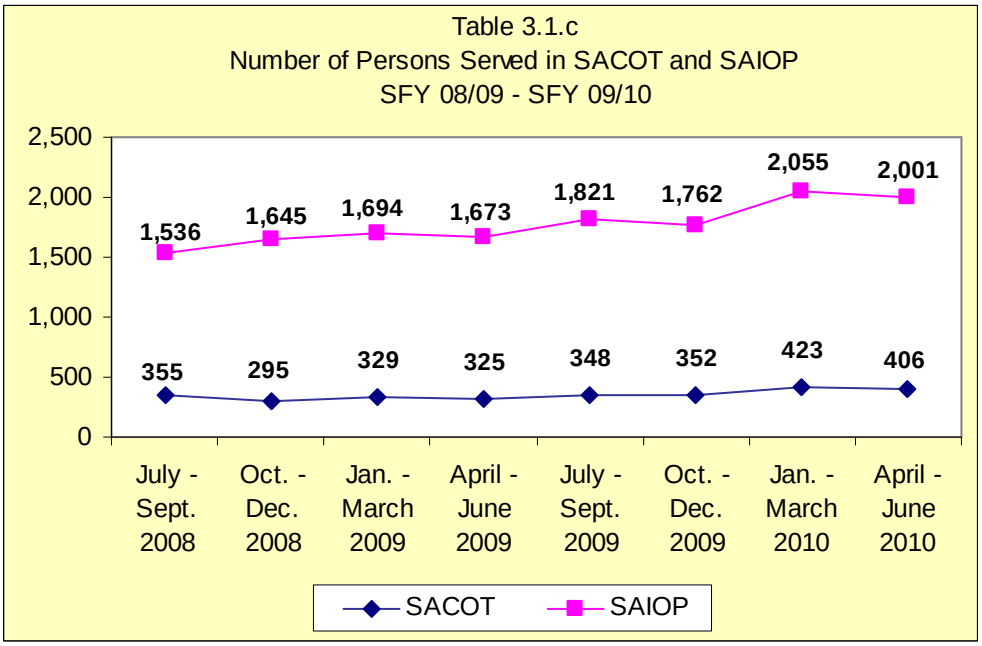
SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - June 30, 2010.

Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children placed in residential and inpatient care. Table 3.1.b shows that the number of youths served in IIH has increased 500% during the past two state fiscal years while the number of youths served in MST increased 51% in the same time period.



SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - June 30, 2010.

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. SAIOP has seen a 30% increase in the number of persons served since the first quarter of SFY 2008-09 (see Table 3.1.c below). SACOT services have remained relatively stable with only slight fluctuations in the last two years serving a low of 295 consumers in the second quarter of SFY 2008-09 to a high of 423 consumers in the third quarter of SFY 2009-10.



SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - June 30, 2010.

The increases in use of evidence-based mental health and substance abuse practices over the past two years reflects the Division's efforts to promote intensive, cost-effective services that help individuals move toward recovery and independence from the public service system. However, the required reductions to service funds this fiscal year could have the impact of reducing the number of providers able to offer these services. **The Division is working to define a well-balanced array of services, so that the *distribution* among types of enhanced services offered can be balanced, even if the overall number of best-practice service providers does not grow during the current economic environment.**

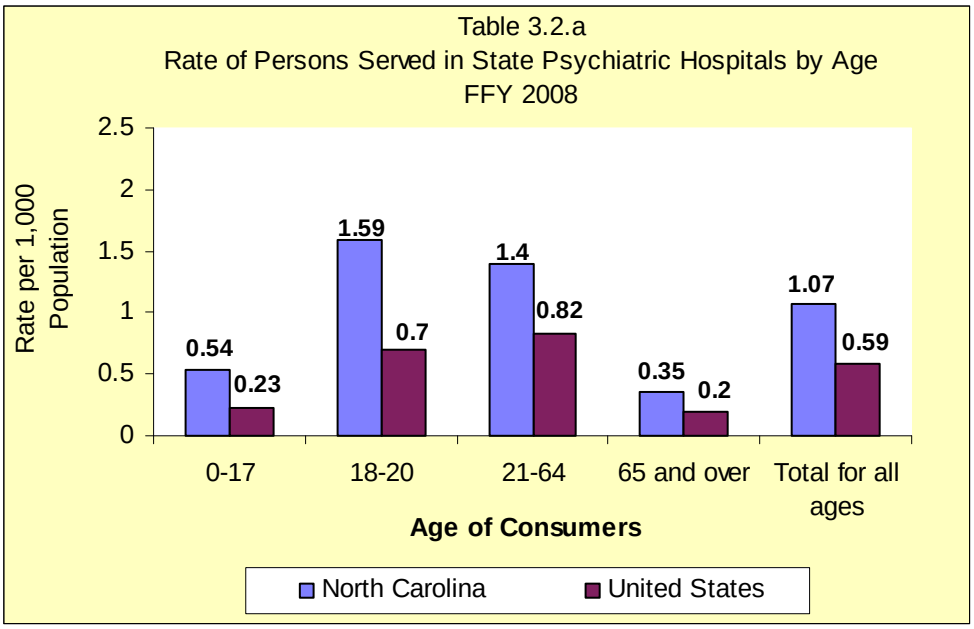
Measure 3.2: Use of State Operated Services

Psychiatric Hospitals: A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. As discussed under Measure 3.1 above, service systems that provide community-based crisis response services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in previous reports, North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina,

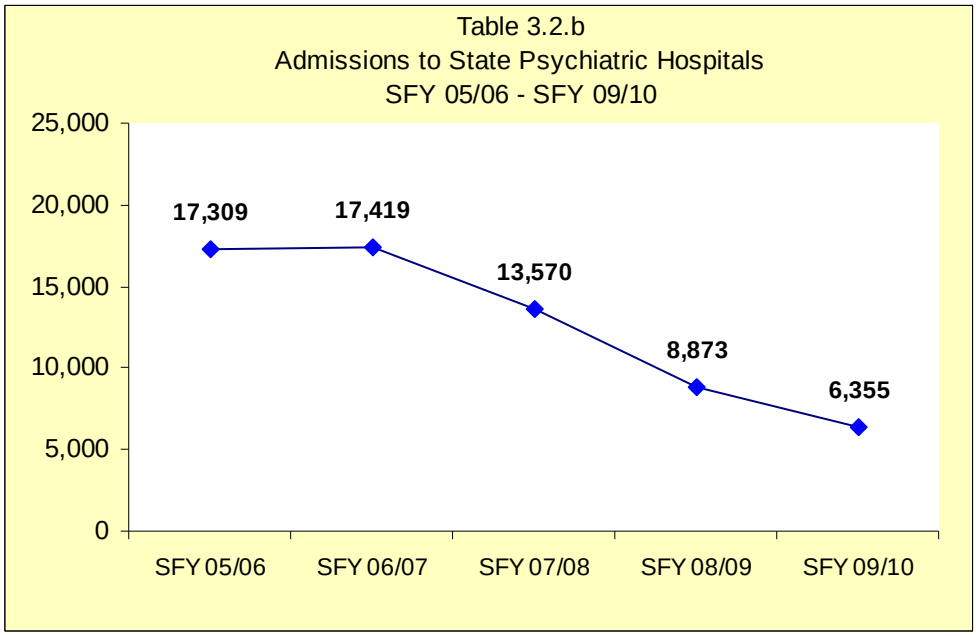
however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay.

According to Table 3.2.a North Carolina has continued to provide treatment for persons in its state psychiatric hospitals at approximately twice the national rate across all ages, according to the most recent report (federal fiscal year (FFY) 2008) from the Center for Mental Health Services (CMHS).



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2008.

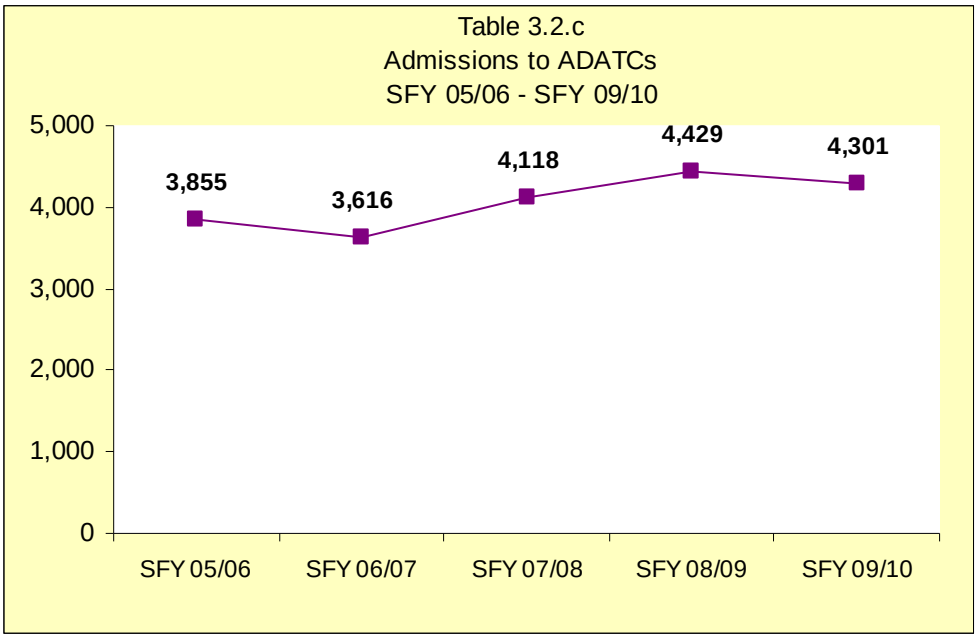
Over the past five years, the number of admissions to the state psychiatric hospitals has been significantly reduced, as shown on the next page in Table 3.2.b. Since SFY 2005-06, the number of admissions to the state psychiatric hospitals decreased by almost two-thirds. This is likely due both to increases in community inpatient capacity and to policies to delay admissions when state hospitals are over capacity.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for state psychiatric hospital admissions during July 1, 2005 - June 30, 2010.

Over the past few years, the Division has used funds appropriated by the Legislature to expand inpatient psychiatric care in community settings. These additional inpatient services, coupled with the community crisis services discussed above, allowed for an 11 percent increase in the number of persons served in community hospitals using state funds in SFY 2009-10, while decreasing the average stay and cost per person by 11%. **The Division expects these new community services to help relieve the admissions pressure on state psychiatric hospitals.**

Alcohol and Drug Abuse Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues to work with the Division of State-Operated Healthcare Facilities (DSOHF) to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. Due to an increase in acute capacity in the ADATCs and enhanced management practices, total admissions to ADATCs has climbed substantially from 3,855 in SFY 2005-06 to 4,301 in SFY 2009-10 (a 12% increase). With the opening of acute units, the ADATCs are now able to serve individuals with substance abuse problems that are under Involuntary Commitment and then provide step-down inpatient services prior to discharge to ongoing treatment in the community**.** In addition to making needed substance abuse care more available and continuous, this increased capacity helps to relieve the inappropriate use of state psychiatric hospitals for persons with substance abuse disorders. **The Division expects admissions to ADATCs to continue increasing over the current fiscal year.**

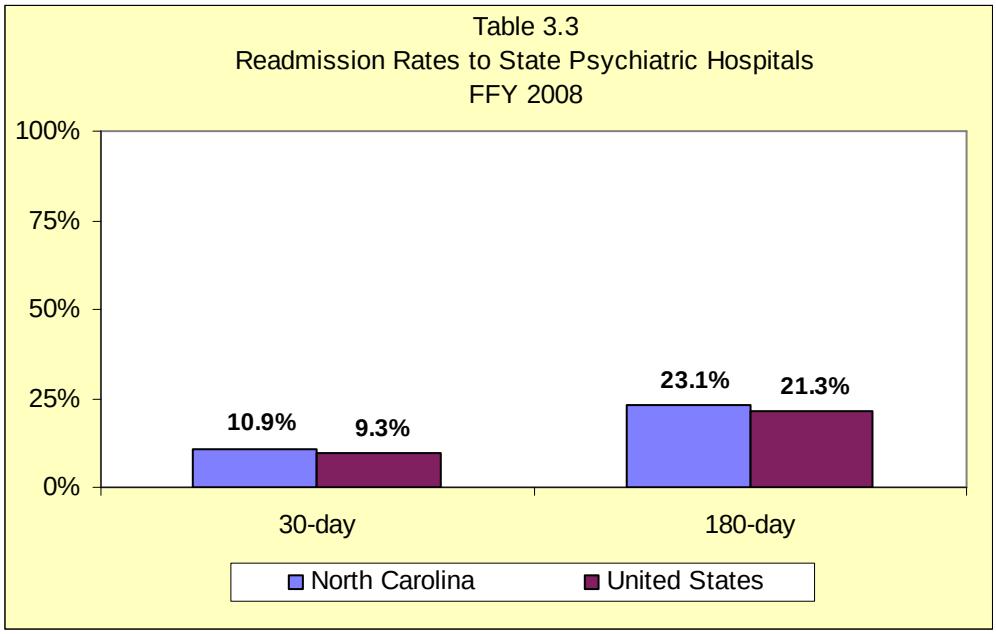


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2005 - June 30, 2010.

Measure 3.3: State Psychiatric Hospital Readmissions

An effective service system provides enough support to help prevent consumer crises and minimize their impact through appropriate planning and treatment. Recurring hospitalization for persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days of discharge is a critical measure of consumer care (adopted by SAMHSA's Center for Mental Health Services) that provides the two Divisions with information on where more comprehensive services might be needed.

Table 3.3, on the next page, shows the percent of consumers requiring readmission to state hospitals within 30 days and within 180 days of discharge. In North Carolina as well as nationwide, the readmission rate is more than double when comparing the 30 day follow-up period to the 180 day follow-up period. Also, as seen in the table on the next page, North Carolina state psychiatric hospital readmissions are somewhat higher than that of the nation for both the 30-day and 180-day time periods. **The two Divisions expect that expanded access to community crisis services will decrease readmissions to state psychiatric hospitals. However, if the availability of intensive community services is constrained by the current economic downturn, the number of crises among fragile consumers may increase the demand on all types of inpatient hospital care.**



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2008.

Measure 3.4: Transitions to Community from State Developmental Centers

The Division of State-Operated Healthcare Facilities and DMHDDSAS are working together to increase opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.[6] This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. During SFY 2009-10, a total of 13 individuals were discharged from the general population of the developmental centers to the community.[7] All 13 individuals went directly from services at the developmental centers to services in the community. Table 3.4 on the next page shows the type of community setting to which the individuals moved.

While movement of individuals to community settings has continued slowly, the Divisions expect that the NC-START program will increase opportunities for individuals to move to community settings in SFY 2009-10 by ensuring access to necessary crisis and respite services.

[6] Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

[7] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

Table 3.4
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
SFY 2009/10

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2009	3	3 to supervised living home
October – December 2009	2	1 to ICF-MR group home 1 to natural family
January – March 2010	4	1 to ICF-MR group home 1 to supervised living home 1 to natural family 1 to medical facility/hospital
April – June 2010	4	4 to supervised living home

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system improvement is building a recovery-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

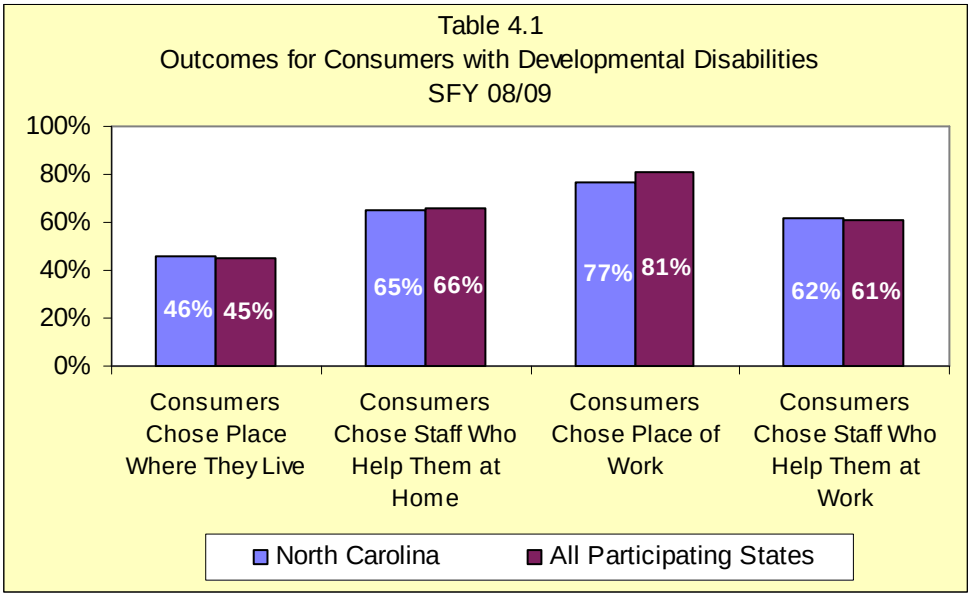
All persons – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include a wide variety of measures of consumers' perceptions of service outcomes and measures of functioning in areas such as:

- Symptom reduction, abstinence, and/or behavioral improvements
- Housing stability and independence
- Enhanced employment and education
- Social connectedness
- Reduction in emergency department and hospital inpatient care
- Reduction in criminal involvement
- Participation in self-help and recovery groups

Based on analysis of data on consumer outcomes, the Division adopted improvements in two of these areas – housing and employment / education – as objectives in the *State Strategic Plan 2007-2010*. Results of initiatives in these areas can be found in the *Spotlights on Progress Reports* at http://www.ncdhhs.gov/mhddsas/stateplans/plans_accomplishments/index.htm#spotlight

Measure 4.1: Outcomes for Persons with Developmental Disabilities

As seen in Table 4.1, in annual interviews with DD consumers in SFY 2008-09, the majority of individuals in North Carolina reported having input into life decisions. (See Appendix D for details on this survey.) While less than half of consumers with developmental disabilities reported choosing where they live, 65% reported choosing the staff that help them in their home. Over three-fourths of the consumers in North Carolina reported choosing their place of work and 62% of consumers reported choosing the staff persons who assist them in their work.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09.

The Division expects that the state's focus on education and employment opportunities will continue to increase choices for consumers, although this progress may be slowed by the impact of the current economic downturn.

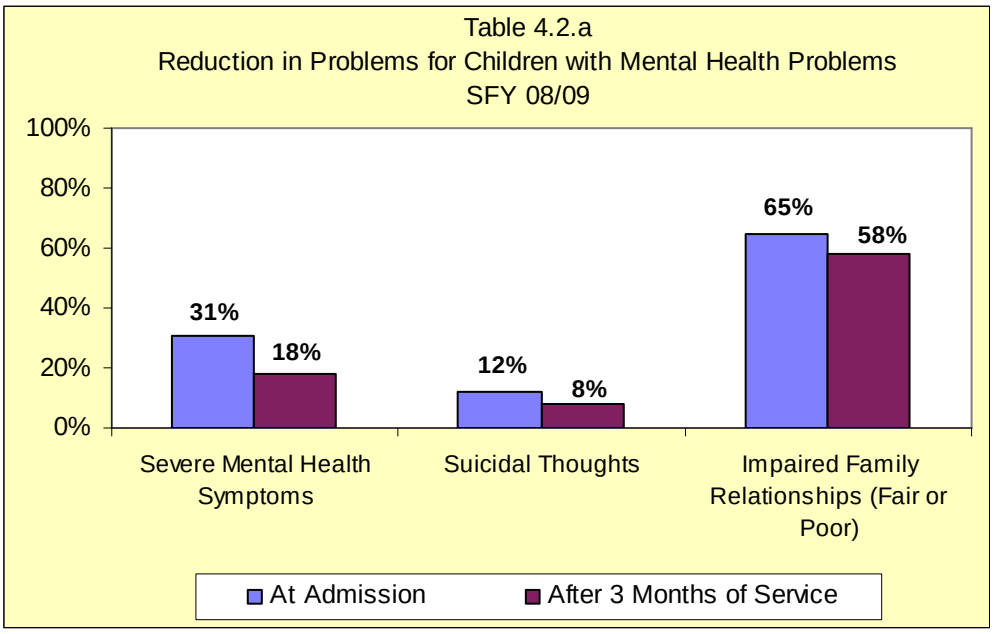
Measure 4.2: Outcomes for Persons with Mental Illness

For persons with mental illness, SAMHSA is focusing National Outcome Measures on reducing symptoms that limit consumers' abilities to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from NC-TOPPS consumer interviews below. (See Appendix D for details on the NC-TOPPS system used to collect this data.)

The Division has been recognized nationally for its NC-TOPPS consumer outcomes system that provides excellent evidence of a service system that is impacting the positive well-being of consumers throughout the system. The system is pivotal to the efforts of the Divisions, LMEs and providers to effectively implement and evaluate quality care that is both accountable and cost-effective.

Table 4.2.a shows improvement in the lives of children under age 12 with mental health problems (who received at least three months of treatment during SFY 2008-09). All of these areas below showed improvements after three months of treatment, the most noticeable being a thirteen percentage point drop

in severe mental health symptoms. This improvement is extremely important and points to treatment that has made a positive impact in the lives of these consumers.



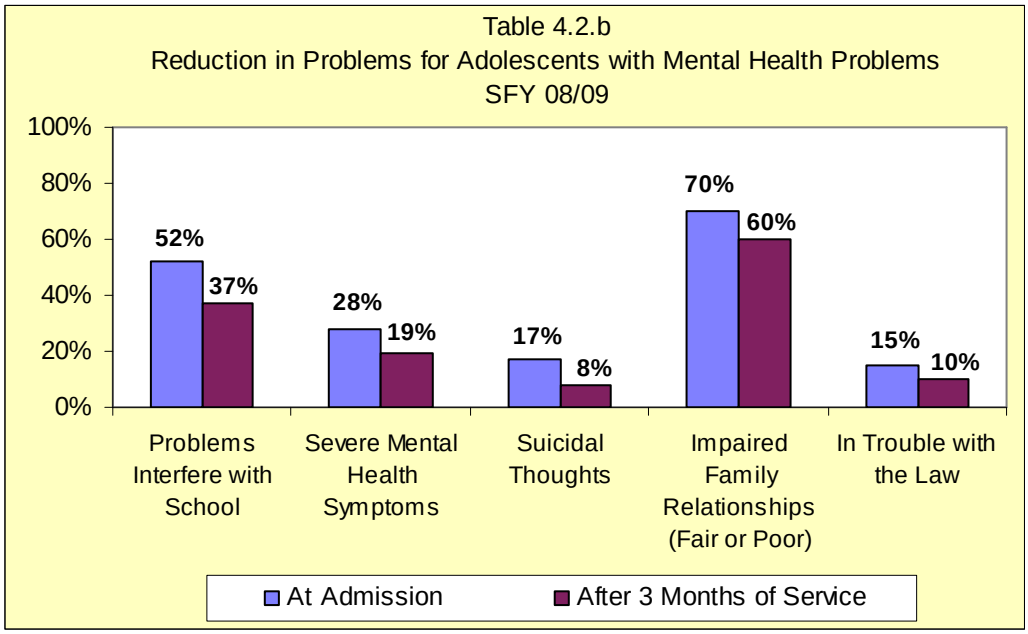
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

Table 4.2.b shows improvement for adolescents (ages 12 to 17) with mental health problems (who received at least three months of treatment during SFY 2008-09) in all of the following areas: problems in school, severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law.

- The rate of suicidal thoughts was cut in half between the time of admission to after three months of treatment (from 17% to 8%, respectively).

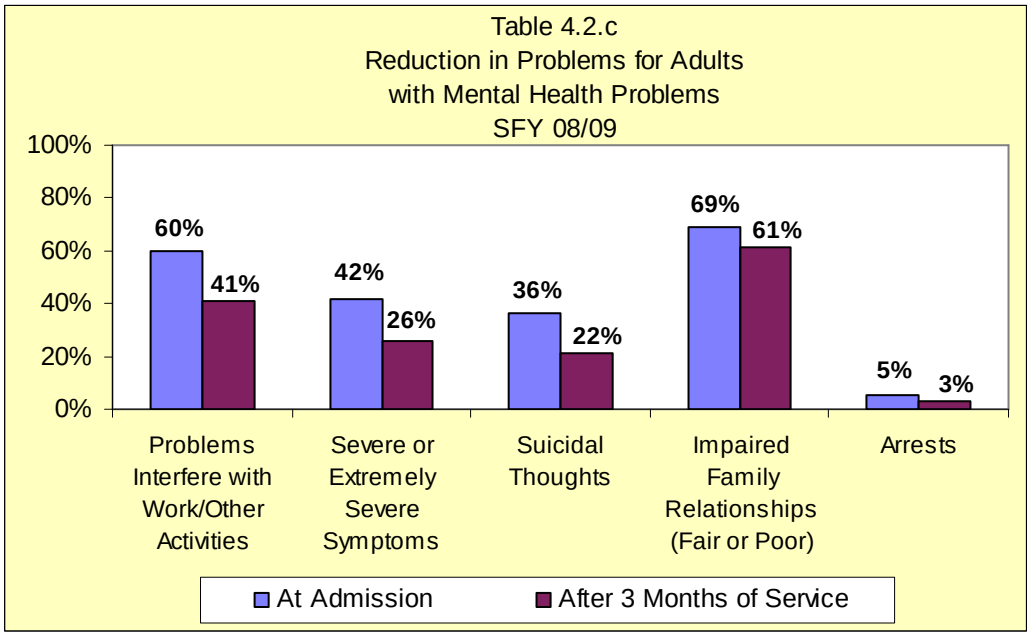
- Arrests and mental health symptoms each decreased by one third between the time of admission to after three months of treatment.

- The most improvement is seen in a fifteen percentage point decrease in adolescents having problems that interfere with school. The importance of this improvement cannot be over-emphasized in promoting the wellbeing and enhanced functionality of these youth in this critical life domain.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

As seen in Table 4.2.c on the next page, progress was made in the lives of adults with mental health problems in reducing their symptoms and the problems associated with those symptoms after only three months of treatment. Similarly to adolescents, the greatest gain was in reduction of problems with work or other activities (down 21 percentage points). Other noteworthy gains were made in reducing the severity of mental health symptoms (down 16 percentage points) and suicidal thoughts (down 14 percentage points). In addition, some improvements were made in family relationships as well as reducing arrests during treatment. Collectively, these findings are very meaningful in portraying the effectiveness of treatment of adults with mental health problems.

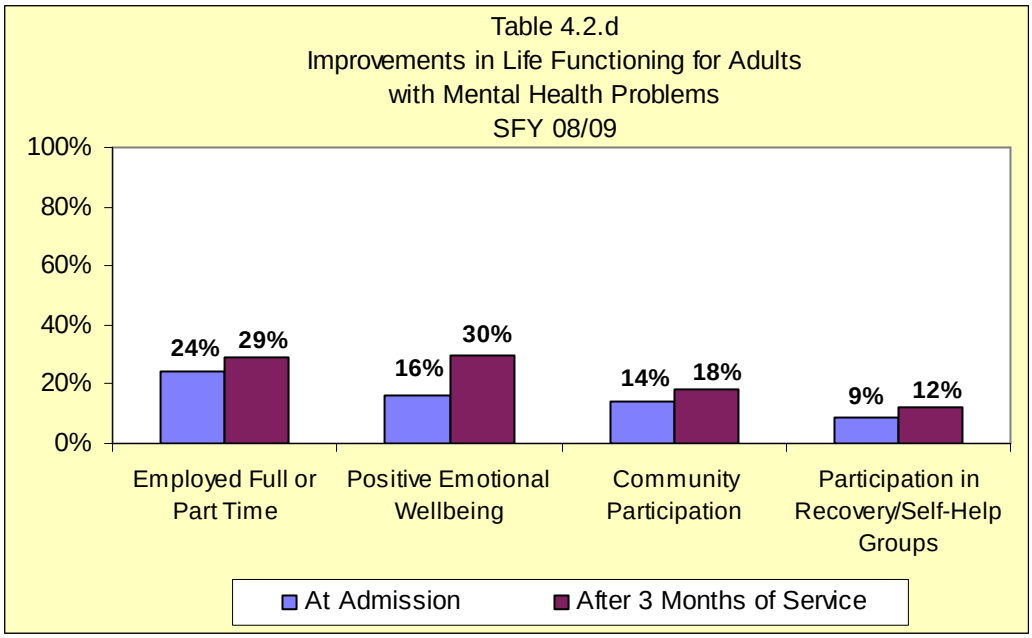


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

Three months of service also made a positive difference in the quality of life for adults with mental health problems as seen in Table 4.2.d on the next page.

- Even in difficult economic times for the state as a whole, the percent of adults employed full or part-time increased five percentage points during treatment.
- The greatest gain was made in the percent of adults reporting positive emotional wellbeing (increase of 14 percentage points).
- The percent of adults participating in positive community activities and recovery or self-help groups increased slightly.

These gains all point to significant strides of these adults in moving into lives of increased security, stability and integration in the community.



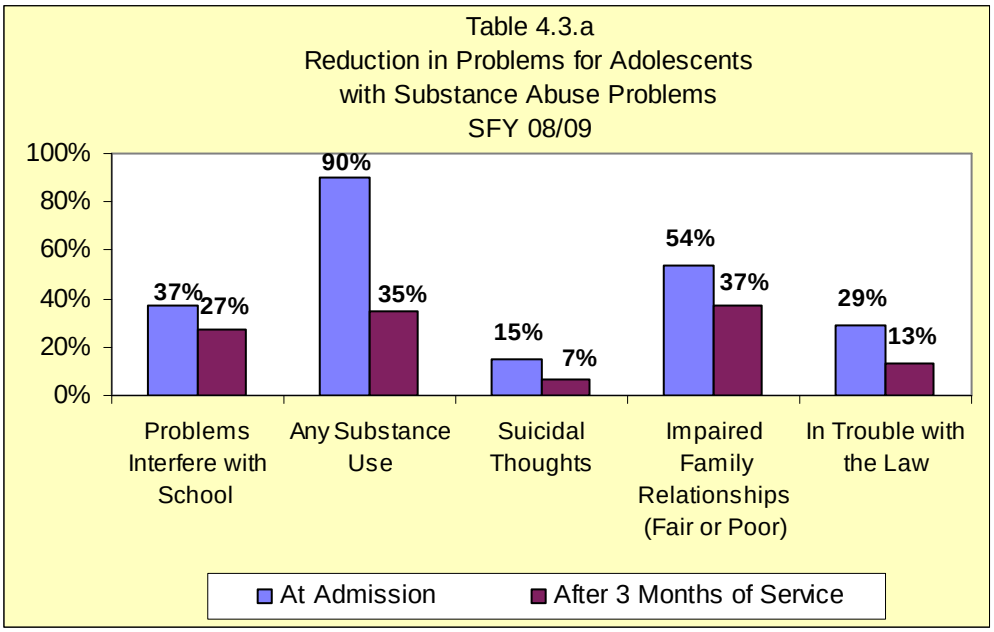
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

Adults, as well as children and adolescents, who remain engaged in services for more than three months can be expected to continue improving in all of the areas shown above. **With continuous appropriate services based on person-centered goals, the Division expects to see long lasting improvements in these areas, although progress may be slowed by the impact of the current economic downturn.**

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

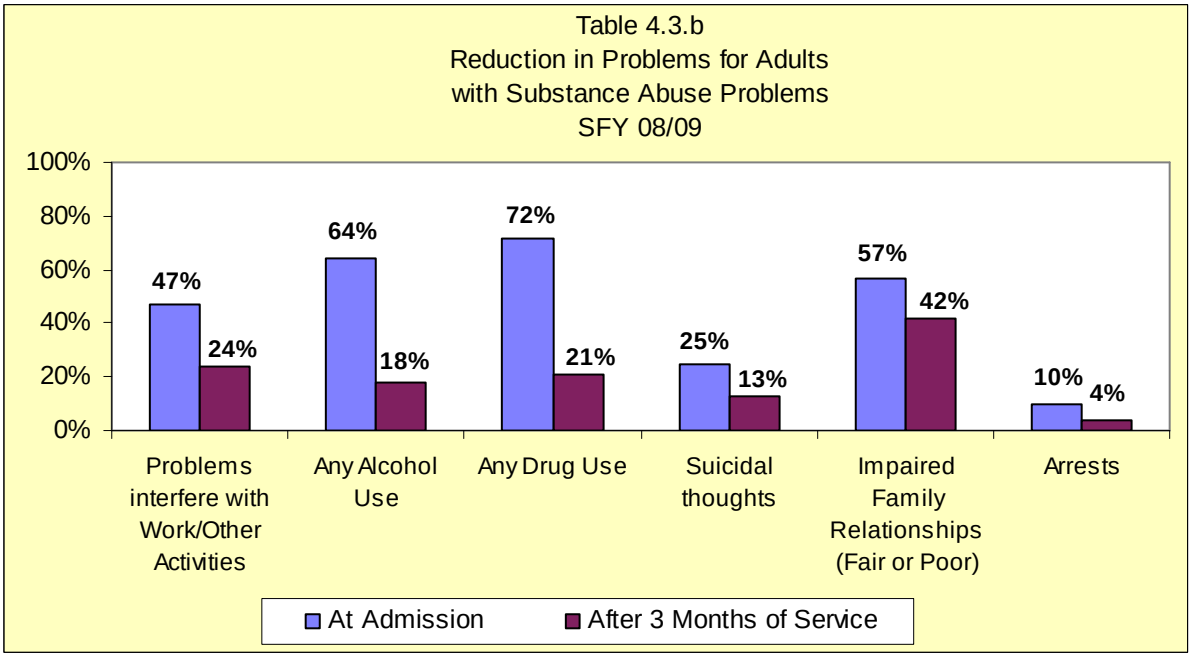
SAMHSA National Outcome Measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from NC-TOPPS consumer interviews below. (See Appendix D for details on the NC-TOPPS system used to collect this data.)

Table 4.3.a shows that adolescents (ages 12 to 17) with substance abuse problems (who received three months of treatment during SFY 2008-09) showed meaningful improvement in a variety of areas of their lives. Most notably, the percent of youth who used substances decreased drastically (a drop of 55 percentage points) and those experiencing suicidal thoughts and in trouble with the law dropped by more than half. In addition, youth with impaired family relationships decreased by 17 percentage points and problems interfering with school saw a decrease of ten percentage points. The importance of these critical gains cannot be overemphasized in portraying the effectiveness of treatment services in dramatically decreasing consumer problems across a variety of critical life domains.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

Similar progress was made among adults in reducing substance use and related problems as shown in Table 4.3.b below. The most notable decreases can be seen in the percent of adult consumers using drugs or alcohol. The decrease in the use of drugs among adult consumers was 51 percentage points and the decrease in the use of alcohol was 46 percentage points. In addition, the percent of adults that had problems interfere with their daily activities or had suicidal thoughts was roughly cut in half while the percent of adults arrested decreased by more than half. These kinds of significant, life-changing improvements cannot be overstated.

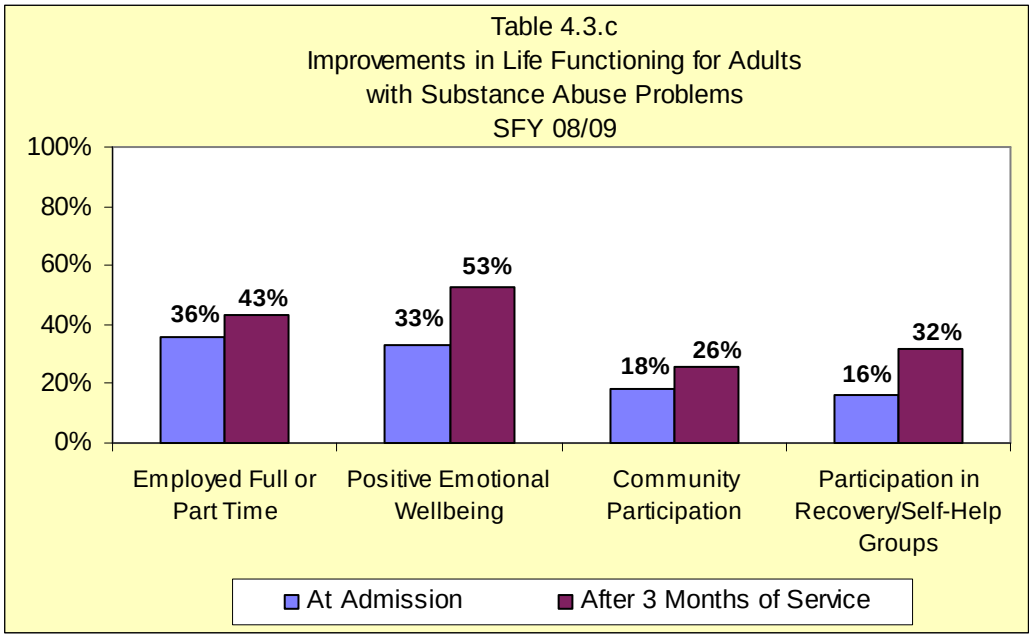


SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

Table 4.3.c shows that services also had a positive impact on the quality of life of adult substance abuse consumers.

- As with adult mental health consumers, the percent of adults employed full or part-time increased during treatment (from 36% to 43%).
- The percent of adults reporting positive emotional wellbeing increased from a third at admission to more than half after three months of service.
- The percent of adults participating in positive community activities increased by eight percentage points.
- The percent of adults participating in recovery or self-help groups doubled.

Again, these changes in client wellbeing and positive adjustment suggest the strength and effectiveness of treatment across multiple critical life domains.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2008 - June 30, 2009 matched to 3-Month Update Interviews.

As seen for adult mental health consumers, helping adult substance abuse consumers maintain and improve their employment situation is an area with room for improvement. This area, of course, is significantly impacted by the broader economic environment which varies dramatically across the state. **The Division expects those who remain engaged in services for more than three months to continue improving in this and other areas of their lives, even though progress may be slowed by the impact of the economic downturn.**

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Pilot of Provider Performance Reports

The Division is preparing to pilot performance reports for individual provider agencies, beginning with selected CABHAS that offer mental health services. (See Measure 6.2 for more information on CABHAs.) The purpose of these annual provider reports is to (1) assist individuals in the selection of service agencies, (2) guide local and state oversight, policy and planning decisions, (3) provide standardized benchmarks for evaluating provider quality, (4) support evaluation of the impact of DHHS initiatives, and (5) help providers learn from peers. Each agency report will include:

- Descriptive information about the agency, including services offered, time in business, and time accredited,
- Oversight agencies' monitoring results
- LME's assessment of confidence
- Consumers' perceptions of the agency
- Consumers' progress toward recovery

A draft of the two-page report template was disseminated in May 2010 and revised based on feedback from consumers, providers and other stakeholders. Preliminary reports will be distributed to each agency participating in the pilot in SFY 2010-11. After incorporating feedback from those agencies, the final reports will be made available to the public in SFY 2011-12.

Measure 5.2: North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) Query System

Over the past year, the Division has worked to increase the utility of its consumer outcomes system, North Carolina Treatment and Outcome Program Performance System (NC-TOPPS). In the fall of 2010, a newer version of the online reporting system was released. This online report system allows the public to view and print graphs showing current statewide, LME and provider-specific information on meaningful outcomes for substance abuse and mental health consumers. The data for these important measures, which include National Outcomes Measures, such as alcohol and drug use, employment, homelessness and

mental health symptoms, are updated on a monthly basis displaying the most recent six months' data. The new version not only allows the public to now view outcomes data on individual providers of mental health and substance abuse services; it also provides multiples way to view and compare data (see screen shot below). A user can (1) build a custom report for an individual agency or LME that includes multiple outcome measures, (2) search for all agencies that belong to a corporate umbrella agency and produce a custom report of multiple outcome measures for the "umbrella agency" (multiple locations across the state), and (3) compare multiple LMEs and/or provider agencies (up to five) alongside the state on one particular outcome measure. The new and improved "Outcomes at a Glance" dashboard can be found at the NC-TOPPS page of the Division's website at http://www.ncdhhs.gov/mhddsas/nc-topps/.

NC-TOPPS Outcomes at a Glance 2.0:

Making current data readily and easily accessible is essential to good system coordination, management and improvement at both state and local levels. **The Division expects to continue enhancing its data systems and reports, while improving their usefulness for knowledge management and quality improvement as budget considerations allow.**

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

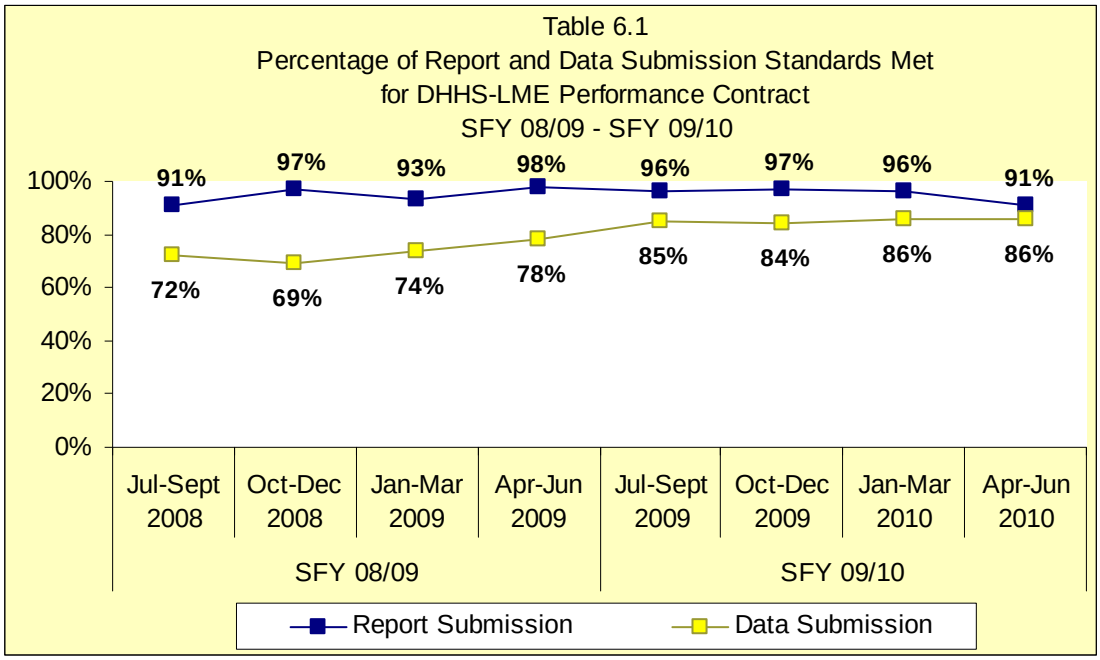
Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform, reporting expectations, and critical system performance indicators.

Measure 6.1: Business and Information Management

Consumer data reported by the LMEs is coupled with claims data to generate the information that the Division uses to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely, complete and accurate submission of consumer and program information. The LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, LMEs' submission of timely and accurate information to the Division has fluctuated during the past two state fiscal years. In all quarters, LMEs' have consistently performed better with meeting the report submission requirements than meeting the data submission requirements. Data submission has improved steadily over the past two years (an increase of 14 percentage points from first quarter of SFY 2008-09 to the fourth quarter of SFY 2009-10). While LMEs are doing better with submission of reports than with the submission of data, report submission has fluctuated over the course of the two years. These are meaningful improvements but will need continued attention.



SOURCE: Data from SFY 2008-09 and SFY 2009-10 Quarterly Performance Contract reports.

Since much of the LMEs' data on consumers now comes from private providers, increased coordination and communication between LMEs and providers is necessary to ensure the timely flow of information. The Department provides information to LMEs on Medicaid-funded consumers to help ensure timely notification about individuals served in the catchment area. The LMEs, in turn, use this information to monitor the provision of consumer services and providers' compliance with data reporting requirements.

Due to budget cuts for SFY 2009-10, the Division is seeking ways to streamline or reduce reporting requirements without compromising the LMEs' and Department's capacity to use data to manage the service system. **The Division expects compliance to continue to vary somewhat as providers and LMEs struggle to meet these demands with fewer resources to dedicate to such crucial administrative activities.**

Measure 6.2: Critical Access Behavioral Health Agency (CABHA) Monitoring

The DHHS has approved a definition and description of a new category of provider agency, a CABHA. The CABHA represents a new category of provider agency for the delivery of mental health and substance abuse services. The implementation of CABHA requirements is designed to improve the quality of care and likelihood of positive outcomes for consumers. CABHA-certified providers pass a rigorous review process in order to achieve that designation. The Department's goals in developing the CABHA designation are to (1) ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services; (2) move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment; and (3) ensure that consumer care is based upon a comprehensive clinical assessment and an appropriate array of services for the population to be served.

In order to assure that CABHAs continue to meet quality-of-care and consumer-outcome standards, an outcome-based monitoring protocol was developed with input from consumers, families, CABHAs, and LMEs, including LME Medical Directors. In addition to regular local monitoring, the CABHA monitoring will focus on eight key domains including: (1) achievement of personal outcomes for

consumers, (2) medical and clinical leadership, (3) use of community-based treatment services to address crisis needs, (4) appropriate referral patterns, (5) quality management plan, (6) integration with physical health care, (7) the provision of core services, and (8) regulatory compliance. Administrative rules regarding expectations for CABHAs and monitoring protocols are currently being finalized. CABHA monitoring will begin in SFY 2010-11.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mental health, developmental disability, and substance abuse problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Measure 7.1: Fetal Alcohol Spectrum Disorders (FASD)

The Fetal Alcohol Spectrum Disorders (FASD)[8] Initiative is being paid for through the Substance Abuse Block Grant Prevention dollars and the work is being contracted through Mission Hospital in Asheville, North Carolina. The initiative is committed to preventing and treating FASD. To expand the reach of the FASD Awareness and Prevention Initiative, the Division has trained substance abuse prevention professionals who work in NC's Centers for Prevention Resources (CPRs), which are responsible for supporting the development of prevention services across the state. The professionals at the CPRs can now include information on FASD in their trainings and seek training opportunities for groups most impacted by FASD. This training and partnership provides a much broader reach across the state to educate the public and prevention staff about FASD and expand the prevention message. For more information on FASD, visit the SAMHSA FASD Center for Excellence website at: http://www.fasdcenter.samhsa.gov/.

Measure 7.2: Traumatic Brain Injury (TBI) and Veterans Initiatives

As the number of military service members with TBI continues to increase, our state system will be called upon to assist with services. Consumers with TBI often have the co-occurring disorders of substance abuse and/or mental health and need several types of services. The Division continues to strengthen its connections with active duty military, as well as working closely with the National Guard and Reserves to triage service members and refer them to military health systems or to private treatment, as appropriate. These ongoing partnerships will strengthen the entire system to get service as soon as possible to all individuals seeking services for TBI, substance abuse and mental health issues.

Conclusion

The information provided in this report summarizes the status of the service system over the past fiscal year. Overall, during this time the public MH/DD/SA service system made progress from previous years, an indication that the efforts of the Division and its local partners have met measured success. However, the economic challenges that North Carolina faces are beginning to show an impact on previous progress.

[8] FASD refers to a spectrum of conditions that include fetal alcohol syndrome, fetal alcohol effects, alcohol-related neurodevelopmental disorder, and alcohol-related birth defects.

In addition to managing cuts in service and administrative funding, the state's MH/DD/SA service system faces significant challenges this fiscal year, including:

- Transition of consumers from community support to other appropriate services
- Transition of children and adolescents from group homes to more appropriate settings
- Implementation of new CABHAs
- Exploration of ways to increase coordination of behavioral and physical health care
- Reduction in the administrative responsibilities of LMEs and providers without jeopardizing consumer health or safety
- Development of two additional CAP-MR/DD Medicaid waiver tiers
- Implementation of new Medicaid waiver programs, similar to the one currently managed by Piedmont Behavioral Health LME.
- Preparation for implementing Healthcare Reform

While these initiatives provide great challenges, they also provide great opportunities to make the service system more efficient and effective. Meeting these challenges will foster greater collaboration among the Division and its state and local partners, integration of services and functions across agencies, and creativity thinking among all participants.

Appendix A: Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, NC G.S. 122C-102(c) was revised to read:

"The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State's progress in these performance areas."

Appendix B: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

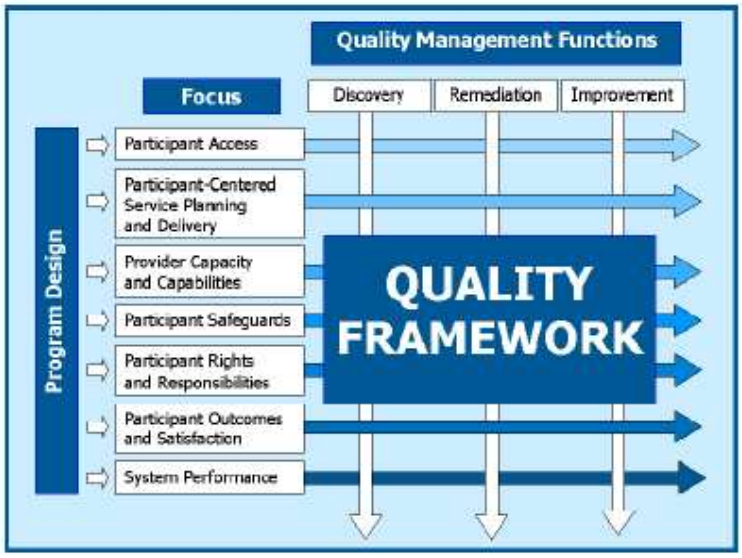
DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix C: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

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Appendix D: Description of Data Sources

Domain 1: Access to Services

Tables 1.1.a – 1.1.c Persons Served: The Division Client Data Warehouse (CDW) provides data on persons served. This system is the primary repository for data on persons receiving public mental health, developmental disabilities, and substance abuse services. It contains consumer demographic and diagnostic information from extracts of the LMEs' management information systems and DHHS service reimbursement systems. It also contains information on consumers' use of state-operated facilities and consumer outcomes extracted from the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) and the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) described below.

The number of persons served (unduplicated) is calculated by adding the active caseload at the beginning of the fiscal year (July 1) and all admissions during the fiscal year (July 1 through June 30) and subtracting discharges during the fiscal year. The disability of the consumer is based on the diagnosis reported for the consumer on paid IPRS and/or Medicaid service claims. The consumer's age on June 30 at the end of the fiscal year is used to assign the consumer to the appropriate age group (e.g. children or adults).

Table 1.2 Persons Seen within Fourteen Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next 14 days and multiplying the result by 100. The information comes from data submitted by LMEs and published in the *Community Systems Progress Reports*. The sources are LME screening, triage, and referral logs and quarterly reports submitted by the LMEs. The data reflect consumers who requested services from an LME. It does not include data on consumers that directly contacted a provider for an appointment. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the *Community Systems Progress Report* can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Domain 2: Individualized Planning and Supports

Tables 2.1.a and 2.2.a Choice among Persons with Developmental Disabilities: The data presented in these tables is obtained through in-person interviews with consumers in the project year 2008-09, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities via in-person interviews and their parents and guardians via mail surveys. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b and 2.2.b Choice among Persons with Mental Health and Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. This confidential survey asks questions about the individual's access to services, appropriateness of services, service outcomes, and satisfaction with services. More information on the MHSIP-CS can be found at: http://www.mhsip.org/. Annual reports on North Carolina's survey can be accessed at: http://www.ncdmh.net/dsis/LMEdirectory.html.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Persons Receiving Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Tables 3.2.a and 3.2.b Management of State Hospital Usage: The data on the rate of persons served in state psychiatric hospitals by age groups of consumers comes from the North Carolina Community Mental Health Services Block Grant report, which is based on data in HEARTS, the system used to track consumer care in state-operated facilities. The data on state hospital admissions in SFY 2005-06 through SFY 2009-10 comes from data in HEARTS. The Division also reports this information in the North Carolina Psychiatric Hospital Annual Statistical Report, which is published by the Division and based on data in HEARTS. This report can be found at:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Table 3.2.c Admissions to ADATC Facilities: The data on admissions to ADATCs in SFY 2005-06 through SFY 2009-10 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The Division also reports this information in the North Carolina ADATC Annual Statistical Report. This report can be found at:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Tables 3.3 State Psychiatric Hospital Readmission: The data on state hospital readmissions (30 days and 180 days after discharge) in FFY 2008 come from the North Carolina Community Mental Health Services Block Grant report, which is based on data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated healthcare facilities.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2009-10 and come from reports submitted quarterly by the developmental centers to the Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Table 4.1 Outcomes for Persons with Developmental Disabilities: This information is obtained through in-person interviews with consumers as part of the NCIP, described in Tables 2.1.a and 2.2.a above.

Tables 4.2.a - 4.3.c Service Outcomes for Individuals with Mental Health and Substance Abuse Disabilities: This information comes from the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule through clinician-to-consumer interviews for all persons ages 6 and over who receive specific mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps.

Domain 5: Quality Management

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last state fiscal

year. This report tracks LME performance in submitting required data and reports to the Division. Some requirements are quarterly while others are semi-annual or annual requirements. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates over the four fiscal quarters represented. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Domain 7: Prevention and Early Intervention

Measure 7.1 North Carolina Strategic Prevention Framework State Incentive Grant: Information on the FASD Initiative can be found on the SAMHSA FASD Center for Excellence website at: http://www.fasdcenter.samhsa.gov/.

Measure 7.2 Traumatic Brain Injury (TBI) and Veterans Initiatives: The Division's TBI Program has more information located on the Division's website at: http://www.ncdhhs.gov/mhddsas/tbi/index.htm